SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
Filing Company:	*American General Life and Accident Insurance Company*	*State Tracking Number:*	*40024*
Company Tracking Number:	*AGLA1000-WS-AR (0608)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Worksite Application*		
Project Name/Number:	*Application/AGLA1000-WS-AR (0608)*		

Filing at a Glance

Company: American General Life and Accident Insurance Company

Product Name: Worksite Application	SERFF Tr Num: AMGN-125781739	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 40024
Sub-TOI: H21.000 Health - Other	Co Tr Num: AGLA1000-WS-AR (0608)	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Hyacinth Prince	Disposition Date: 08/27/2008
	Date Submitted: 08/21/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Application	Status of Filing in Domicile: Pending
Project Number: AGLA1000-WS-AR (0608)	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/27/2008	
State Status Changed: 08/27/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The above form is being submitted for your consideration and approval. It is new and does not replace any form previously approved by your department. The referenced form has been submitted to our domicile state of Tennessee.

AGLA1000-WS-AR (0608) is an application to be used by our agents in applying for individual life, critical illness (Critical Care Plus), disability (Disability Care), accident (Emergency Care) and cancer insurance coverages issued on payroll

SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
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deduction premium payment mode in a worksite setting. The Flesch readability score for the Agreement Section of application AGLA1000-WS-AR (0608) is 50.0.

The referenced form is being submitted to your Life Section this date.

If I may provide any additional information, please contact me as shown below.

Company and Contact

Filing Contact Information

Kathryn Mitchell, Manager	kathryn_mitchell@aigag.com
American General Center	(615) 749-1139 [Phone]
Nashville, TN 37250-0001	(615) 749-2521[FAX]

Filing Company Information

American General Life and Accident Insurance Company	CoCode: 66672	State of Domicile: Tennessee
American General Center	Group Code: 12	Company Type:
Nashville, TN 37250-0001	Group Name: AIG	State ID Number:
(615) 749-1139 ext. [Phone]	FEIN Number: 62-0306330	

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	
	1 x 20.00 = $20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American General Life and Accident Insurance	$20.00	08/21/2008	22058343

SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
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Product Name:	*Worksite Application*		
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Company

SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
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Company Tracking Number:	*AGLA1000-WS-AR (0608)*		
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Product Name:	*Worksite Application*		
Project Name/Number:	*Application/AGLA1000-WS-AR (0608)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/27/2008	08/27/2008

SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
Filing Company:	*American General Life and Accident Insurance Company*	*State Tracking Number:*	*40024*
Company Tracking Number:	*AGLA1000-WS-AR (0608)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Worksite Application*		
Project Name/Number:	*Application/AGLA1000-WS-AR (0608)*		

Disposition

Disposition Date: 08/27/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
Filing Company:	*American General Life and Accident Insurance Company*	*State Tracking Number:*	*40024*
Company Tracking Number:	*AGLA1000-WS-AR (0608)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Worksite Application*		
Project Name/Number:	*Application/AGLA1000-WS-AR (0608)*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Worksite Application	Approved-Closed	Yes

SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
Filing Company:	*American General Life and Accident Insurance Company*	*State Tracking Number:*	*40024*
Company Tracking Number:	*AGLA1000-WS-AR (0608)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Worksite Application*		
Project Name/Number:	*Application/AGLA1000-WS-AR (0608)*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AGLA1000-WS-AR (0608)	Application/ Enrollment Form	Worksite Application	Initial		50	1000-WS-AR JD.pdf

American General Life and Accident Insurance Company
American General Center • Nashville Tennessee 37250-0001

WORKSITE APPLICATION

FOR AGENT USE ONLY: New Group ❑ Existing Group ❑
REQUESTED EFFECTIVE DATE _____
EXISTING GROUP NO. _____

Proposed Insured (Print full name)	Street Address	City	State	Zip Code
John Doe	123 4th Street	Little Rock	AR	72203

Social Security #	DOB mm/dd/yyyy/state	Age	☒ M ❑ F	Height	Weight	Home Phone	**Employer**	**Date of Hire** mm/dd/yyyy
111-22-3333	01/01/1973	35		6'0"	190	111-222-3333	Joe's Garage	01/01/2000

Occupation	Job Duties	Length of time in occupation	Annual Earned Income
Mechanic	repairing cars	8 yrs	

Other Sources of Income	Driver's License #	Issue State	SIC Code (DI Only)
	3456789	AR	

First Beneficiary (name, address, relationship, age)	**Second Beneficiary** (name, address, relationship, age)
Jane Doe	

Spouse name (if coverage applied for)	Social Security #	DOB mm/dd/yyyy/state	Age	❑ M ☒ F	Height	Weight
Jane Doe	444-55-6666	01/01/1975	33		5'6"	135

Employer	Date of Hire mm/dd/yyyy	Occupation	Job Duties	Length of time in occupation

Annual Earned Income	Other Sources of Income	Driver's License #	Issue State

Payor	Social Security #	Relationship	Employer	Date of Hire mm/dd/yyyy
John Doe				

Owner	Social Security #	Relationship
John Doe		

Names of child(ren) and legally adopted child(ren) who are: (1) members of your immediate family and (2) under age 18 for whom coverage is applied for:

Full Name	Relationship	Age	Birth date	Sex	Birth Weight & Current Weight (if under age one)
John Doe, Jr.	Son	10	01/01/1998	M	

Life

Plan Term

Face Amt $ 10,000

❑ SI
❑ SI (Select)

Death Benefit Option (UL only)
❑ A ❑ B

❑ Automatic Premium Loan

Riders:
❑ AD / AD&D $ _____ ❑ TIR ❑ CIR
❑ SLTR $ _____ ❑ PW (Traditional) / WMDR (UL)
❑ CTR $ _____ ❑ Other _____ $ _____
❑ DIR 2 - Primary Insured — Monthly Benefit _____ Occ. Class _____
❑ DIR 2 - Additional Insured — Monthly Benefit _____ Occ. Class _____
❑ DIR 5 - Primary Insured — Monthly Benefit _____ Occ. Class _____
❑ DIR 5 - Additional Insured — Monthly Benefit _____ Occ. Class _____

Sec 125 **(Worksite Term Only)**
❑ Yes
☒ No

Monthly Premium $ 3.07

Life **Critical*Care* Plus** **Disability*Care*** **Emergency*Care*** **Cancer**

HOME OFFICE USE ONLY

Critical*Care* Plus

Coverage Period	Proposed Insured(s)	Amounts
☒ 10 years	☒ Primary	$ 10,000
☐ 15 years	☒ Spouse	$ 10,000
☐ 20 years	☒ Child(ren)	$ 10,000
☐ 30 years		
☐ Lifetime		

Riders:
☐ HIV Rider
☐ Primary ☐ Spouse
☐ ADD Rider/Amount
☐ Primary $ _____ ☐ Spouse $_____
☐ Child(ren) $_____

Monthly Premium $ 25.54

Disability*Care*
☐ Base Plan Only
☐ "On the Job" Enhancement
Units_____ (unit = $100 of monthly benefit)
☐ SI ☐ SI (Select)

Elimination Period (days)
☐ 7 ☐ 14
☐ 7 ☐ 14 ☐ 30
☐ 7 ☐ 14 ☐ 30 ☐ 90 ☐ 180
☐ 14 ☐ 30 ☐ 90 ☐ 180

Benefit Period
☐ 3 months
☐ 6 months
☐ 12 months
☐ 24 months

Riders: ☐ AD&D
Units ____
(each unit = $20,000)
☐ Wellness Screening
☐ Other _____ $_____

Monthly Premium $

Emergency*Care*
☐ Individual
☐ Individual & Spouse
☐ Individual & Child(ren)
☐ Family
# of Units_____
☐ SI (Select)

Riders:
☐ **AD&D**
☐ Primary (# of units_____)
☐ Spouse (# of units _____)
☐ Child(ren) (# of units _____)
☐ **Hospital Cash Rider**
(# of units _____)
☐ Other_____

☐ **Accident Only Disability Income**
☐ **Individual** ☐ **Spouse***
(# of units_____) **(# of units_____)**
☐ 24 hour ☐
☐ Off the job ☐
_____ Occupation Class _____
_____ Elimination Period _____
_____ Max. Benefit Period _____

Sec 125
☐ Yes
☐ No

Monthly Premium $

Cancer
☐ Gold ☐ Platinum ☐ Platinum Plus ☐ Other_____ ☐ **Individual** ☐ **Parent & Child(ren)** ☐ **Family**

Sec 125
☐ Yes
☐ No

Monthly Premium $

All Coverages **YES** **NO**

1. Does any proposed insured have any life, health, accident or disability insurance in force or currently applied for with this company or any other company? ☐ ☒
   If "Yes": Name _____ Co. Name _____ Type _____ Amt _____ Pol # _____
   Name _____ Co. Name _____ Type _____ Amt _____ Pol # _____
2. Will any policy applied for replace any existing life, annuity, health, accident or disability income insurance? ☐ ☒
   If "Yes": Name _____ Co. Name _____ Type _____ Amt _____ Pol # _____
   Name _____ Co. Name _____ Type _____ Amt _____ Pol # _____
3. **Is the proposed insured or payor actively at work now and has he/she worked at least 30 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last three months except for minor illness or injury of one week or less, or normal pregnancy?** ☒ ☐
4. Within the past 10 years has any proposed insured been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ ☒
5. Is any proposed insured currently a patient in or been advised to enter a hospital, clinic or treatment facility? ☐ ☒
6. Within the past 5 years, has any proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? ☒ ☐
   If yes, who, what type, frequency and last date: _____
   Primary Proposed Insured: Date of last use: Month 08 Year 2008 Type cigarettes Frequency daily Amount 1 pack ☐ ☐
   Spouse: Date of last use: Month _____ Year _____ Type _____ Frequency _____ Amount _____ ☐ ☐

Life & Critical*Care* Plus

7. Within the past 5 years, has any proposed insured been diagnosed as having or been treated by a member of the medical profession for Multiple Sclerosis, Familial Adenomatous Polyposis (Gardener's Syndrome), loss of hearing or speech, breast(s) tumor or cyst(s), congenital anomalies, colon polyps, blindness or a need for an organ transplant? ☐ ☒

Life, Critical*Care* Plus, Disability*Care*

8. Within the past 5 years, has any proposed insured been diagnosed as having or been treated for Alzheimer's, sickle cell anemia, hemophilia, high blood pressure, a disease or disorder of the eyes, ears, nose, throat, kidneys, liver, thyroid or other glands, blood, blood vessels, lungs or respiratory, reproductive, digestive, circulatory, genitourinary or nervous systems? ☐ ☒
9. Within the past 24 months, has any proposed insured experienced unexplained dizziness, chest pain, shortness of breath, numbness or paralysis? ☐ ☒

Life, Critical*Care* Plus, Disability*Care*, Cancer	**YES**	**NO**
10. Within the past 5 years, has any proposed insured been diagnosed as having or been treated for cancer, leukemia, melanoma, tumor or malignant growth, Hodgkin's Disease, non-Hodgkin's lymphoma, polycystic ovary(ies) or colon polyps?	❑	X
11. Within the past 6 months, has any proposed insured been advised by a member of the medical profession of any abnormal diagnostic test results, had treatment for sores that have not healed, had changes in the appearance of a mole, had unexplained weight loss, blood loss or fatigue or been advised to have any diagnostic tests (including self administered), hospitalization, treatment or surgery which was not completed?	❑	X
Life, Critical*Care* Plus, Disability*Care*, Emergency*Care*		
12. Within the past 5 years, has any proposed insured been diagnosed as having or been treated for diabetes, stroke, mental illness, heart disease, seizure disorder, loss of sight or limb, a disease or disorder of the musculoskeletal system, alcohol use, drug use or used intravenous drugs, cocaine, barbiturates or hallucinogens?	❑	X
13. Within the past 5 years, has any proposed insured had a reckless driving charge, had a drivers license revoked or suspended or within the past three years had multiple moving violations in any vehicle(s) operated by the proposed insured?	❑	X
14. Within the past 24 months, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the future?	❑	X
15. Within the past 12 months, has any proposed insured engaged in parachuting, hang gliding, underwater diving, the racing of a motor powered land vehicle or watercraft, or avocation generally considered dangerous or does any proposed insured have any intentions to do so in the future?	❑	X
Life, Critical*Care* Plus, Disability*Care*, Emergency*Care*, Cancer		
16. Does any proposed insured have a pending appointment with any physician or other medical professional or have the intent to make such appointment within the next 30 days?	❑	X
17. Has any proposed insured ever had a life, disability, health or critical illness application modified, rated, declined, postponed, withdrawn, cancelled or refused for renewal?	❑	X
Life, Emergency*Care*		
18. Has any proposed insured ever been convicted of or plead guilty or no contest to a felony or does such person have a pending felony charge?	❑	X
Critical*Care* Plus		
19. Has any member of any proposed insured's immediate family (mother, father, sister, brother) ever been diagnosed as having or been treated for heart disease, stroke, cancer, cerebrovascular disorder, aneurysm or diabetes prior to age 55?	❑	X
Disability*Care*, Disability Income Riders		
20. Have you applied for or received disability benefits (other than for routine pregnancy) or made a claim for worker's compensation benefits in the last two years?	❑	❑
21. In the last 12 months, have you missed more than 5 consecutive days or 10 total days of work due to illness or injury (not related to pregnancy)?	❑	❑
22. Have you ever been diagnosed as having or been treated for or consulted a member of the medical profession for chronic fatigue syndrome, fibromyalgia, rheumatoid arthritis, complications of pregnancy, Crohn's Disease, a disease or disorder of the connective tissues or of the back or spinal cord?	❑	❑
23. Within the past 6 weeks have you taken any prescription medication (not including prescription contraceptives or allergy medication)?	❑	❑
Life $100,000 and up		
24. In the past 5 years, has any proposed insured consulted a doctor or been a patient in a hospital, clinic or treatment facility?	❑	❑
25. Is any person proposed for coverage NOT a U.S. citizen? If, yes, does any proposed insured intend to travel or reside outside of the United States within the next year?	❑	❑

REMARKS – Explain "Yes" answers to questions 1-25 as appropriate, including explanation if no driver's license.

Name of Person(s)	Date	Duration	Details of Illness, Impairment, Checkup or Driving Record	Names / Addresses of Dr. or Hospital

Consent To Insurance On Life of Minor

I consent to the insurance plan, amount and beneficiary designation shown on the application and also reaffirm the answers to the health questions as they pertain to the Minor primary Proposed Insured.

Signature of Parent or Legal Guardian

Relationship

AGREEMENT – AUTHORIZATION – ACKNOWLEDGMENT – UNDERSTANDING – NOTICE

I, the Primary Proposed Insured (and any Owner or Spouse signing below), by my signature set forth hereafter: Agree to, Acknowledge receipt of (as applicable), Authorize, and Understand the following: I **AGREE:** (a) All statements and answers in this application are complete and true to the best of my knowledge and belief; (b) No agent has authority to waive any answer or otherwise modify this application or to bind American General Life and Accident Insurance Company ("The Company") in any way by making any promise or representation which is not set out in writing in this application; and (c) If premiums for the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy(ies) and that this does not change my effective date of coverage. If the policy(ies) is (are) not issued, American General will refund any deductions it receives. I **AUTHORIZE:** the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurer and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to which I have applied or may apply for insurance coverage, or other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization at any time by written notification to the Company at its Home Office. I agree that a facsimile of this Authorization shall be as valid as the original and this Authorization shall be valid for two years from the date shown below. I **ACKNOWLEDGE:** Receipt of the following notices: (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; and (c) Outline of Coverage, if applicable. For Accident and Health Insurance only, I **UNDERSTAND:** that (a) by applying for any of the coverages shown on this application, I am not applying for a major medical insurance policy; (b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable; and (c) If premiums for coverage applied for in this application are paid with pre-tax dollars under a Section 125 (cafeteria) plan, benefits may be taxable. If so, my beneficiary or I may incur a tax obligation. I should consult my personal tax advisor for more information about how this may affect me. **NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

PRIMARY PROPOSED INSURED - If a Consumer Investigative Report is prepared in connection with this application:
☒ I elect to be interviewed. ☐ I elect NOT to be interviewed.

SPOUSE - If a Consumer Investigative Report is prepared in connection with this application:
☒ I elect to be interviewed. ☐ I elect NOT to be interviewed.

Agent – To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? ☐ Yes ☒ No

Signed at Little Rock (City) AR (State)

John Doe — Signature of Primary Proposed Insured (if age 16 or over) — August 1, 2008 (Date)

Sally Shield — Signature of Licensed Agent — Date

Jane Doe — Signature of Spouse (If Included As A Proposed Insured) — August 1, 2008 (Date)

Sally Shield
Printed Name of Licensed Agent

Signature of Owner (If other than Primary Proposed Insured) — Date

(Signature of witness, other than the agent, when signature is by mark) — Date

Agent's Certification

I certify that I have asked each question and that the answers have been truly and accurately recorded as given to me. I have recorded any unfavorable information which I have knowledge of concerning any Proposed Insured. I confirm that any and all signatures in this application were signed in my presence.

Sally Shield — Signature of Licensed Agent

August 1, 2008 — Date

HOME OFFICE USE ONLY

NOTICE OF INFORMATION PRACTICES

American General Life and Accident Insurance Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes)

AGLA NIP (1004)

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American General Life and Accident Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642 for hearing impaired). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

American General Life and Accident Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

AGLA MIB (1004)

SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
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Company Tracking Number:	*AGLA1000-WS-AR (0608)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Worksite Application*		
Project Name/Number:	*Application/AGLA1000-WS-AR (0608)*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMGN-125781739*	*State:*	*Arkansas*
Filing Company:	*American General Life and Accident Insurance Company*	*State Tracking Number:*	*40024*
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Product Name:	*Worksite Application*		
Project Name/Number:	*Application/AGLA1000-WS-AR (0608)*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Certification/Notice	Approved-Closed	08/27/2008
Comments:			
Attachment:			
ARCERT1.pdf			

		Review Status:	
Bypassed -Name:	Application	Approved-Closed	08/27/2008
Bypass Reason:	New application under Form Schedule Tab.		
Comments:			

		Review Status:	
Bypassed -Name:	Health - Actuarial Justification	Approved-Closed	08/27/2008
Bypass Reason:	Not applicable to this filing.		
Comments:			

		Review Status:	
Bypassed -Name:	Outline of Coverage	Approved-Closed	08/27/2008
Bypass Reason:	Not applicable to this filing.		
Comments:			

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

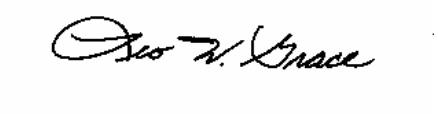
ARKANSAS CERTIFICATION

Subject: AGLA1000-WS-AR (0608) Worksite Application

This is to certify that, to the best of my knowledge and belief, the above form complies with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act; the Flesch score is as follows:

Form Number	Flesch Score
AGLA1000-WS-AR (0608)	50.0

Leo W. Grace



Vice President

DATE August 21, 2008